Illinois Department of Public Aid

no. A-200-03-01

ILLINOIS MEDICAL ASSISTANCE PROGRAM
PROVIDER BULLETIN

05/06/03

TO: Participating Physicians and Hospitals

RE: Handbook for Providers of Physician Services May 2003 Update

The purpose of this bulletin is to provide updated pages for the Handbook for Providers of Physician Services. The handbook update contains clarification regarding the Department's reimbursement for injectable drugs administered in a physician's office.

Effective immediately, injectable drugs administered in a physician's office, with the exception of Botox, Amevive 7.5 mg vial and 15 mg vial, will no longer require prior approval. Physicians should bill the appropriate CPT or HCPCS procedure code for the administered drug.

Replacement pages for the Handbook for Providers of Physician Services are available on the Department's website at <**http://www.state.il.us/dpa/html/physicians.htm**>. If you do not have access to the Internet, or need a paper copy, printed copies are available upon written request. You need to specify a physical street address to ensure delivery. Submit your written request or fax to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
Fax Number: (217) 557-8800
E-mail address is **PPU@mail.idpa.state.il.us**

The revised pages are dated May 2003. The affected items are designated by "=" signs to the left. The pages to be removed and replaced are listed in this bulletin.

INSTRUCTIONS FOR UPDATING HANDBOOK

A-221.2 Dispensed Items

Remove page dated December 1998 II-A-21 and insert page II-A-21 dated May 2003
Remove page dated December 1998 II-A-22 and insert page II-A-22 dated May 2003

Appendix A-I Preparation and Mailing Instructions-Form DPA 2360, Health Insurance Claim Form

Remove page dated December 1998 Appendix A-I (6) and insert page Appendix A-I (6) dated May 2003

A-221 PHARMACY ITEMS

A-221.1 PRESCRIPTION REQUIREMENTS

Pharmacy items which are essential for the accepted medical treatment of a client's presenting symptoms and diagnosis are covered items for which payment can be made by the Department, when they are prescribed or dispensed in accordance with the following requirements and limitations.

Coverage of prescription pharmacy items and over the counter drugs is limited to those produced by drug manufacturers who have signed drug rebate agreements. A listing of rebating manufacturers is distributed quarterly by the Department. Pharmacy items, both prescription and over-the-counter items, which are covered in the Medical Assistance Program may be prescribed or dispensed in accordance with specified policy and procedure.

= The physician is to use the physician's own prescription form and is responsible for entering on the form the following minimal information:

- Client's name
- Date of prescription
- Name of pharmacy item being prescribed
- Dosage form and strength or potency of drug (or size of non drug item)
- Quantity
- Directions for use
- Refill directions
- Physician's Medical Assistance program Identification Number/License Number
- Signature in ink and legible
- Drug Enforcement Administration (DEA) Number (or the Social Security Number of those physicians who do not have a DEA Number.)

Physicians may not charge for the writing of prescriptions.

Prescriptions are not to be written for injectables which are to be given in the physician's office unless the acquisition cost of the injectable equals or exceeds $25.00.

Physicians are to prescribe, and pharmacies are to dispense, medications in quantities reasonably calculated to meet the predictable needs of the patient as long as this does not exceed the designated maximum quantity.

Patients who are on extended maintenance therapy defined as prolonged use of the same drug, strength, and daily dosage quantity should be issued prescriptions for a 30 day supply per dispensing. The exception to this policy is for birth control pills for which up to a 90 day supply may be dispensed.

The completed prescription form is to be given to the client to take to the pharmacy of the client's choice; however, a physician may telephone or electronically transmit a pharmacy to prescribe, provided that the client is permitted free choice of pharmacy.

A-221 **PHARMACY ITEMS** (Continued)

A-221.1 **PRESCRIPTION REQUIREMENTS** (Continued)

The client's medical record in the physician's office is to contain entries regarding all drugs, medications with dosages, and medical supplies which are prescribed or dispensed, and the patient's response to the treatment. When medications are dispensed to a client, the physician shall comply with all aspects of Section 33 of the Medical Practice Act, particularly those relating to prescription labeling and record keeping.

A-221.2 **DISPENSED ITEMS**

Charges may be submitted for drugs dispensed in an emergency, or when not readily obtainable from a pharmacy.

PROCEDURE: The specific drug dispensed is to be identified in Field 24C of the Form DPA 2360 with the appropriate Item Number from the Department Drug Manual (Section IV of the Handbook). The number of tablets/capsules dispensed is to be shown on the claim in Days/Units Field 24F.

= When an injectable is supplied and administered by the physician, the appropriate CPT or HCPCS procedure code is to be entered in Field 24C of the Invoice. The drug name, strength, and quantity must be shown in the narrative sections of the invoice.

See Appendix A-1, Field 24C and 24F for detailed billing instructions for dispensed drugs.

For drug items specifically coded, reimbursement will be made in the amount of the charge, not in excess of the Department's maximum or established acquisition costs. Whether dispensed by the physician or pharmacy, the brand name version of a drug available generically is reimbursed at the reimbursement rate for the generic unless prior authorization for the branded version is obtained. Drugs are considered available generically if they are listed in the Illinois Department of Public Health’s Illinois Formulary for the Drug Product Selection Program.

No charges may be made for anesthesia agents administered for office surgical procedures or for sample items dispensed.

A-221.3 **EXCEPTIONS**

Limitations apply for clients eligible for the Child and Family Assistance Program or for the Transitional Assistance Program, category 07.

COMPLETION STATUS	FIELD	
		When the repeat box is completed, it must contain a capital "X". Any other character will be ignored. The physician may change any field or fields in the subsequent service section by entering the changed data.
Required	24A	**Date of Service** - Enter the date the service was performed. Use MMDDYY format.
Required	24B	**P.O.S. (PLACE OF SERVICE)** - Enter the numeric or alpha code which identifies the place where the service was provided: 1 Inpatient Hospital 2 Outpatient Hospital 3 Doctor's Office 4 Patient's Home 5 Day Care Facility (PSY) 6 Night Care Facility (PSY) 7 Nursing Home 8 Skilled Nursing Facility 0 Other Locations B Other Medical/Surgical Facility C Residential Treatment Center D Specialized Treatment Center E Emergency Department
Required	24C	**Proc. Code/Drug Item No.** - When billing for services, enter the appropriate five-digit procedure code as specified in this Handbook or, if not specified, from CPT-4 or HCPCS. When billing for dispensed drugs, enter the eight-digit drug item number from the Drug Manual and enter the name and strength of the drug dispensed. The number of tablets/capsules dispensed is to be shown on the service line in the DAYS/ UNITS field (24F).

COMPLETION STATUS	FIELD
=	If an injectable was administered, the appropriate CPT or HCPCS procedure code is to be entered. The drug name, strength, and quantity of the vial dispensed must be shown in the narrative section of the claim.
Conditionally Required	**Modifying Units** 1) **Anesthesia**: Enter the appropriate alpha code (see Appendix A-14) to identify the anesthesia modifier units when type of service is code 7, Anesthesia. 2) **Healthy Kids Instructions**: When a procedure code for a Healthy Kids screening referral is used, an entry should be made in the MOD field, on the same line as the screening procedure code. J Referral to self for further medical diagnosis/treatment K Referral to other provider for further diagnosis/treatment L Referral to dentist for evaluation